STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

AND

OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

AND

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

VANDERBILT HEALTH PLANS, INC.

NASHVILLE, TENNESSEE

FOR THE PERIOD JANUARY 1, 2000 THROUGH DECEMBER 31, 2000

TABLE OF CONTENTS

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
TENNCARE DIVISION
500 JAMES ROBERTSON PARKWAY, SUITE 750
NASHVILLE, TENNESSEE 37243-1169
615-741-2677 Phone
615-532-8872 Fax

TO: Manny Martins, Deputy Commissioner TennCare Bureau
Tennessee Department of Finance and Administration

Anne B. Pope, Commissioner
Tennessee Department of Commerce and Insurance

VIA: Patricia L. Newton, Acting Deputy Commissioner
Tennessee Department of Commerce and Insurance

Lisa R. Jordan, Acting Assistant Commissioner
Tennessee Department of Commerce and Insurance

Gregg Hawkins, Assistant Director
Office of the Comptroller of the Treasury
Division of State Audit

CC: C. Warren Neel, Commissioner
Tennessee Department of Finance and Administration

FROM: Paul Lamb, CPA, TennCare Manager
Gregory Hawkins, CPA, TennCare Lead Examiner
Georgeanne Martin, CPA, TennCare Examiner
Karen Degges, Legislative Auditor
Rachel Banks, Legislative Auditor
Tammy Farley, Legislative Auditor

DATE: August 1, 2002

SUBJECT: Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Vanderbilt Health Plans, Inc.

A market conduct examination of claims processing and a limited scope financial examination of Vanderbilt Health Plans, Inc., 215 Centerview Drive, Suite 300, Brentwood Tennessee, 37027, was completed May 23, 2001. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination report "by test" of the claims processing system of Vanderbilt Health Plans, Inc. (VHP). A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

Further, this report reflects the results of the limited scope review of financial statement account balances as reported by VHP and of VHP's compliance with certain contractual requirements.

II. PURPOSE AND SCOPE

A. Authority

This examination of VHP was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the TennCare contract between the State of Tennessee and VHP, Executive Order No. 1 dated January 26, 1995, and Tenn. Code Ann. § 56-32-215.

VHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

This examination focused on the claims processing functions and performance of VHP. Sixty claims processed in January 2001 were selected for testing from a data file previously submitted to TDCI by VHP.

The limited scope financial examination focused on the balance sheet and income statement as reported by VHP in its National Association of Insurance Commissioners (NAIC) Annual Statement for the period ended December 31, 2000.

The fieldwork was performed from April 30, 2001, through May 23, 2001.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that VHP's operations were administered in accordance with the TennCare contract as well as state statutes and regulations concerning HMO operations. The examination also provides reasonable assurance that VHP TennCare members receive uninterrupted delivery of health care services on an on-going basis.

The objectives of the examination were to:

- Determine whether VHP met its contractual obligations under its Contractor Risk Agreement with the state (the "TennCare contract") and whether VHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;

- Determine whether VHP had sufficient financial capital and adequate risk reserves to ensure the uninterrupted delivery of health care services for its TennCare members on an on-going basis;

- Determine whether VHP properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether VHP had corrected deficiencies outlined in prior reviews of VHP conducted by the Comptroller or examinations conducted by TDCI.

III. PROFILE

A. Brief Overview

Vanderbilt Health Plan, Inc., was incorporated in the State of Tennessee on May 14, 1993, for the purpose of providing managed health care services to individuals participating in the state's TennCare Program. On September 3, 1993, TDCI granted VHP a certificate of authority to operate as an HMO. VHP has participated in the TennCare Program since its inception on January 1, 1994.

VHP was a wholly-owned subsidiary of Vanderbilt Health Services, Inc. (VHS), which was a wholly-owned subsidiary of Vanderbilt University (VU). VHP owned 100% of Vanderbilt Management Services, Inc. (VMS), its management company and 92% of Health 123, Inc. (H123), a commercial HMO. VMS owned the remaining 8% of H123. VHP reported the combined net worth of its two subsidiaries as limited by T.C.A. § 56-3-303(c) as an asset, Investment in Subsidiary, on its

balance sheet. VHP reported the income (loss) of the two subsidiaries as the Results of Subsidiary Operations on its Statement of Revenues, Expenses and Net Worth.

In December 2000, VHP sold 100% of the stock of its wholly owned subsidiary, Vanderbilt Management Services (VMS) to Health Plans Holding Corporation (HPHC) with an effective date of August 31, 2000. The terms of the agreement also required VMS to transfer its 8% ownership of H123 to VHP. This transfer increased VHP's ownership in H123 from 92% to 100%.

In March 2001, HPHC purchased from VHS 100% of the stock of VHP. VHS received 1,111,111 shares of common stock of HPHC, warrants to purchase an additional 1,388,889 shares of common stock of HPHC, and a subordinated note from VHP in the amount of $4,231,300. The effective date of the transaction was August 31, 2000. In conjunction with the purchase of VMS by HPHC, VHP was required to dividend to its former parent, VHS, 100% of the stock ownership of H123.

VHP is licensed by TDCI to operate in the community service area of Davidson County. VHP derives the majority of its revenue in the form of capitation payments from the state for providing medical benefits to TennCare members. As of December 31, 2000, VHP had approximately 14,000 TennCare members.

On August 21, 2001, TDCI approved a material modification of VHP's certificate of authority to allow the HMO to change its name from "Vanderbilt Health Plans, Inc." to "Victory Health Plan, Inc."

B. Claims Processing Not Performed by MCO

During the examination period, VHP contracted with Eckerd, Inc., as its pharmacy benefits manager responsible for the provision of TennCare pharmacy benefits and for processing and paying claims related to these services. As a result, claims for pharmacy services were not included in VHP's pool of claims from which the claims were selected for testing; therefore, no pharmacy claims were tested for compliance with section 2-18. of the TennCare contract and Tenn. Code Ann. § 56-32-226(b) (the "Prompt Pay Act").

IV. PREVIOUS EXAMINATION FINDINGS - CLAIMS PROCESSING

The following were claims processing deficiencies cited in the examination report by the Comptroller of the Treasury, Division of State Audit, for the period January 1, 1997 through December 31, 1998:

1. VHP did not meet the claims processing timeliness standards set forth in the TennCare contract.

2. Some claims selected for testing could not be located.

3. All encounter data elements were not entered into the claims processing system.

4. Errors were found in the payment and denial of claims.

5. Differences were found between the date claims were received per the claims processing system and the actual received date stamped on claims.

6. Out-of-pocket expenses were not correctly accumulated.

7. VHP did not have the ability to accept electronic claims.

Findings 2, 4 and 7 have been satisfactorily corrected. Findings 1, 3, 5 and 6 will be repeated in the current report.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies-Claims Processing Market Conduct Examination

The following deficiencies were determined to exist during the claims processing market conduct examination of VHP:

1. VHP did not process claims in accordance with the timeliness standards set forth in the TennCare contract and the Prompt Pay Act in January 2001.

2. All the encounter data elements reported on nine claims were not recorded completely and accurately in the claims processing system.

3. VHP did not send explanations of benefits to enrollees with deductible/coinsurance responsibility.

4. The benefit accumulator did not accurately accumulate two enrollees' out-of-pocket expenses.

5. The weekly claims processing report for April 20, 2001, did not include claims information regarding claims processed by VHP's pharmacy contractor. Also, no

documentation was provided for the average turnaround time for adjudicated claims reported on the weekly claims processing report.

6. Claims received at the main office in Brentwood, Tennessee, were not date stamped and logged before VHP sent them to the claims processor in Oklahoma.

B. Summary of Deficiencies – Limited Scope Financial Examination

The following deficiencies were determined to exist during the limited scope financial examination of VHP for the year ended December 31, 2000:

1. Twenty-one outstanding checks were not properly written-off.

2. The review of the March 2001 medical loss ratio (MLR) report, which covered the period from July 1, 2000 through March 31, 2001, revealed several discrepancies.

3. The management fees for the period under examination were not calculated in accordance with the management contract in effect during the year.

VI. DETAIL OF TESTS CONDUCTED - CLAIMS PROCESSING SYSTEM

A. Claims Selected For Testing

VHP contracted with Shared Medical Systems ("SMS") in Tulsa, Oklahoma to process its provider claims, excluding pharmacy claims. SMS uses the Diamond claims processing system.

Sixty claims with dates of service during the period January 1, 2000 and December 31, 2000 were selected from the January 2001 data file previously submitted to TDCI by VHP. For each claim processed, the data file included the amount paid and, if applicable, an explanation of the reason for denial. The claims from the data file were judgmentally selected for testing as follows:

- Thirty-two denied claims were selected with at least one claim from each claim type and one claim for each unique denial code.

- Five large dollar paid claims were selected.

- Twenty-three paid claims were selected at random.

B. Time Study of Claims Processing

1. The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Section 2-18 of the TennCare contract and the Prompt Pay Act. Section 2-18. of the TennCare contract requires an MCO to process 95% of "clean" claims submitted by both contract and non-contract providers within 30 calendar days of receipt, the remaining 5% of "clean" claims within the next 10 calendar days, and 100% of all claims (clean or not clean) within 60 calendar days of receipt. The term "process" means that the MCO must either:

   - Pay the claim (the MCO shall either send the provider cash or cash equivalents in full satisfaction of the clean claim, or give the provider a credit against any outstanding balance owed by the provider to the MCO);

   - Deny the claim, with **all specific reasons** for the denial communicated to the provider; or

   - Advise the provider that there is insufficient information to adjudicate the claim and detail the specific information needed to adjudicate the claim.

   The Prompt Pay Act requires that 90% of clean claims be processed, and if appropriate paid, within 30 days of receipt and that 99.5% of all provider claims be processed within 60 days of receipt.

2. TDCI requested a data file from all MCOs, including VHP, which contained **all** claims processed during the month of January 2001. TDCI used this data file to determine each MCO's compliance with the processing requirements defined in the TCA § 56-32-226(b) and Section 2-18 of the TennCare Contract by calculating the processing time lag based on the claims' received and processed dates. Because these tests were performed on all claims processed in January 2001, projection of the test results to the population was not necessary.

   TDCI's analysis of the claims data file found that, during the month of January 2001, VHP processed 93.7% of all claims within 30 days and 98.2% of all claims within 60 days. Therefore, in January 2001, VHP was neither in compliance with the Prompt Pay Act requirement to process 99.5% of all claims within 60 days of receipt nor the TennCare contract requirement to process all claims within 60 days of receipt.

   It should be noted that effective July 1, 2001, the timeliness requirements in the TennCare contract were changed to be consistent with those set forth in the Prompt Pay Act.

Management's Response

VHP concurs with the finding. VHP was in the midst of changing ownership from Vanderbilt Medical Center to Windsor Health Group as well as changing management from Vanderbilt Management Services to Victory Management Services. Additionally, as part of the changeover in management, VHP was in the process of reviewing and adjudicating some very old claims that had, for various reasons, not been properly handled or paid.

There was also some confusion about our capitated agreement with VUMC. At the time, VHP was the only MCO that made capitated payments to its providers. The providers were paid "up front" for their services and then as the providers submitted claims, VHP provided feedback on claims by either accepting or denying the claims. The auditors initially marked many claims as delinquent when they had actually already been paid but not clearly marked as such. Over the course of several months, VHP worked extensively with John Mattingly to derive with a good measuring tool for prompt payment analysis. Since the audit, VHP has consistently met the prompt payment requirements as required by the State Prompt Pay Act of January 2001.

C. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied or rejected. No discrepancies were noted in adjudication testing.

D. Withhold, Deductible and Copayment Testing

1. The purpose of "withhold testing" is to determine whether amounts withheld from provider payments are in accordance with the provider contracts and are accurately calculated. VHP does not withhold a certain percentage of payments from providers.

2. The purpose of testing deductibles and coinsurance is to determine whether enrollees are subject to out-of-pocket payments on certain procedures and whether out-of-pocket liabilities are calculated within liability limitations in accordance with Section 2-3.k. of the TennCare contract. Seven of the claims selected for review were for services rendered to enrollees who were responsible for coinsurance. The coinsurance liabilities were correctly calculated for these claims. In addition, the claims histories for these seven enrollees were reviewed to determine if the benefit accumulator accurately accumulated the members' out-of-pocket expenses. Out-of-pocket expenses for two of these seven enrollees

were not accumulated correctly causing one enrollee's total liability to exceed the deductible and out-of-pocket maximum for the year.

Management's Response

VHP concurs with the finding. With the upgrade of the Diamond claim system from release 4.3 to release 5.2.3, numerous enhancements to benefit accumulators' files were made. This upgrade eliminated any remaining issues with the accumulator and there have been no further known problems. The upgrade occurred during the week of July 20, 2001.

E. Pended/Unprocessed Claims Testing

The purpose of testing pended claims is to determine the existence of claims that have been pended by VHP, the principal reasons for pending the claims, the number of pended claims that are over 60 days old, and whether a potential material unrecorded liability exists. VHP provided the examiners with a pended claims report for each claim type (HCFA 1500 and UB 92) as of April 26, 2001. There were no claims in process for more than 60 days. The oldest claim on the pend report was received February 26, 2001. There does not appear to be a potential unrecorded material liability as a result of pended claims.

F. Explanation of Benefits (EOB) Testing

The purpose of EOB testing is to determine whether uninsured and uninsurable members (non-Medicaid) who are subject to deductibles and coinsurance are provided an explanation of benefits in accordance with usual and customary health care industry practices.

VHP did not provide EOBs to enrollees whose claims are subject to deductibles and coinsurance; therefore, enrollees were not informed of their out-of-pocket liabilities.

Management's Response

VHP concurs with the finding. VHP made the decision not send EOBs to our TennCare population in late 1999. Not only were the mailings very expensive but with the mobile population of TennCare, we were having a large percentage of the mailings being returned for incorrect addresses. It is also our belief that because the TennCare contract in effect at the time of the audit does not specifically state that MCOs must send EOBs, VHP, in fact, *is not required* to send EOBs. According to the audit comments, the purpose of the EOBs were to provide members a way of manually tracking their out-of-pocket liabilities. VHP's claims system utilizes benefit and out-of-pocket accumulators' to track these amounts

electronically for our members and automatically adjust the member's responsibilities once their out-of-pocket maximums had been reached. TennCare has since advised VHP that it, TennCare, would assume the responsibility of notifying VHP when members reached their maximum out-of-pocket limits.

Since it is customary for MCOs to send EOBs to their non-Medicaid population, VHP agrees to institute a new EOB policy effective January 1, 2003 to mail EOB notifications to our non-Medicaid members (Uninsurables, Non-Insured, and Dual Medicare/Medicaid members).

G. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system. The examiners requested five remittance advices for testing. No discrepancies were noted on the review of the five remittance advices.

H. Analysis of Canceled Checks

The purpose of analyzing canceled checks is to: (1) verify the actual payment of claims by VHP; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested 5 checks for testing. All 5 checks cleared the bank account within 14 days of the issue date and the check amounts agreed with amounts paid per the remittance advices.

I. Comparison of Actual Claim with System Claim Data

The purpose of comparing hard copy claims with the data entered into the claims system is to ensure that the claims data received by VHP is accurately entered into the claims system for proper claims adjudication and encounter data reporting to the TennCare Bureau.

The examiners requested the 60 original claims selected for testing. VHP provided copies of all 60 claims. The data elements from the 60 claims were compared to the data elements entered into VHP's claims processing system. For 9 claims, data elements were not entered or were entered incorrectly into VHP's claims processing system.

- It did not appear that all diagnoses reported on the claim had been entered into the claims processing system. VHP staff indicated that a system constraint

resulted in the examiner's inability to view these diagnoses in the system, but that they had been entered.

- Procedure codes recorded on two claims were incorrectly entered in the claims processing system.

Management's Response

VHP concurs with the finding. VHP instituted a weekly accuracy audit and follow-up training in the two specific areas of clerical and financial accuracy. As examples of our improvements and ongoing commitment in this area, the following results of our own recent internal audits are given below:

04/16/02 – 305 claims audited for week of 4/1-4/4 totaling $29,217.33
99.8% were financially accurate
99.02% were free of clerical errors

04/23/02 – 365 claims audited for week of 4/5-4/11 totaling $30,458.54
100% were financially accurate
99.45% were free of clerical errors

04/30/02 – 399 claims audited for week of 4/12-4/18 totaling $79,135.02
99.90% were financially accurate
100.0% were free of clerical errors

VHP has also actively promoted the use of EDI in claims submission. These promotions have taken place in both the Quarterly Provider Bulletins as well as on-site training at the Provider's offices. As a result, we have seen our EDI rise from a low of 7% at the time of the audit to 57% in April for our Par providers and an overall rate of 51% for all claims. This percentage continues to grow each month. We currently have an outreach program to our Non-Par providers, particularly the Non-Par Hospitals, to strongly encourage them to file using EDI as well.

J. Electronic Claims Capability

Section 2-18. of the TennCare contract states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment.…" Section 2-2.g. of the TennCare contract requires MCOs to move to electronic billing no later than January 1, 1997. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively. VHP has implemented an electronic billing option for claims

submission by providers. EDI claims represented 7.8% of total claims total claims processed during the examination period.

VII. REPORT OF OTHER FINDINGS AND ANALYSES – CLAIMS PROCESSING

A. Weekly Claims Processing Reports

The weekly claims processing report for April 20, 2001, was selected for review and VHP was requested to provide supporting documentation for this report. The weekly claims processing report did not include claims information regarding claims processed by VHP's pharmacy contractor. Also, no documentation was provided for the average turnaround time for adjudicated claims reported on the weekly claims processing report.

Management's Response

VHP concurs with the finding that the pharmacy data was not and has not been included on the Weekly Activity Report. This is in part because we misunderstood the field labeled "Processed by Subcontractors" and assumed that meant the claims processed by SMS, our claims processor and not the pharmacy claims data. As we noted in our previous response, currently, the pharmacy data is reported on a monthly basis. This claims data is reported to Ms. Pam Phillips, an Encounter Specialist, at TennCare. The report consists of two parts, Part One is a detailed breakdown of all pharmacy claims for the previous month and Part Two is a breakdown of all "denied" pharmacy claims for the previous month. Neither our current PBM, CareMark, or our previous PBM, Eckerd, has/had the ability to provide us the claims data on a weekly basis. We will work with CareMark, the current PBM, and see if there is any way that we can get the data reported to us on a weekly basis. As this may take some effort on our part and time on CareMark's part, as an interim step, we will begin reporting on the Claims Weekly Activity Report, the previous month's pharmacy claims data as a special line item the week that the pharmacy claim data is received from CareMark.

VHP concurs with your finding that no backup data was made available to you to support the data provided on the 4/20 claims data report filed with the State. In September, 2001, the IT department took over the filing of these reports and can provide supporting data for reports from that date forward. Please note that the information to calculate the average lag time for periods prior to September, 2001, is available in the IT department's system and the IT department can calculate the average days upon request (as the IT department did for the period 4/16-4/20, 2001). However, what the IT department calculates from the system and what was reported on the reports may or may not agree since the IT department does not have the formula that the other department was using to calculate the number of days prior to the IT department taking the function over.

B. Test of Claims Selected From Mail Room

Providers are instructed to send claims to the claims processor, SMS, in Tulsa, Oklahoma. Some providers, however, sent claims to VHP's Brentwood, Tennessee office. These claims were then forwarded to Oklahoma. VHP did not date stamp or log the claims received in the Brentwood office. Ten claims were selected from the mailroom on May 1, 2001. During fieldwork, the claims were examined in the claims processing system to determine if the correct date of receipt was entered into the system. Eight of the claims had an incorrect received date of May 3, 2001, in the claims processing system. As of May 23, 2001, examiners could not locate the remaining two claims in the claims processing system.

Failure to establish control of all claims immediately upon receipt by VHP results in VHP having no record of these claims being submitted by providers in the event that these claims are lost or misplaced before being received by the claims processor. Also, by not recording the received date in the claims processing system as the date the claims were received by VHP, the processing time lag for these claims is understated.

Management's Response

VHP concurs with the finding. Currently, claims that are received in the Brentwood office are logged as follows:

a. Claim questions sent in by a specific provider are stamped and logged into VHP's CCONT system and forwarded to Siemens (Tulsa) for processing with comments.
b. Claim batches that are inappropriately forwarded to the Brentwood office are stamped and logged into a spreadsheet and then forwarded to Siemens to be processed.
c. Retro authorization requests are reviewed in the medical department and logged into the authorization module. The claim is then forwarded to Siemens to be processed.
d. As noted earlier, VHP strongly encourages our providers to file electronically which automatically send the claim to the correct location for processing.

VIII. REPORT OF FINDINGS AND ANALYSES – FINANCIAL REVIEW

A. Financial Overview

VHP files annual and quarterly NAIC financial statements with TDCI. The department uses this information to determine if VHP meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not to be included in the

determination of plan assets and should be reduced from equity. Additionally, T.C.A. § 56-32-212(5) defines the term "admitted assets" for the purposes of calculating a health maintenance organization's net worth.

On the second amended NAIC annual statement for the year ended December 31, 2000, VHP reported $12,192,569 in admitted assets, $6,302,904 in liabilities and $5,889,665 net worth. VHP reported total revenues of $9,191,949 and total expenses of $21,715,201, resulting in a net loss of $12,523,252 for the period January 1 through December 31, 2000. Revenue is comprised of $23,170,793 in capitation fee payments from the TennCare Program, $399,298 in investment income, and ($14,378,142) in other revenue. Other revenue includes a $3,995,691 Loss on Results of Subsidiaries Operations and a $10,382,451 Loss on Sale of Subsidiaries (VMS). The plan reported $18,965,817 in medical and hospital expenses and $2,749,384 in administrative expenses. Premium tax expense was reported as $463,416. Medical and hospital expenses represent 81.9% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 11.9% of capitation fee payments from TennCare.

C. Financial Tests Performed

TDCI reviewed the account balances on the NAIC Statement for the year ended December 31, 2000 to determine if balance sheet and income statement amounts were properly reported as required by NAIC guidelines and Tennessee Code Annotated. This review included the following tests:

- The independent auditors' report for the year ended December 31, 2000 was reconciled to NAIC Statement for the year ended December 31, 2000.
- Cash and cash equivalents balances were verified through bank statements and bank reconciliations.
- Investment balances were confirmed against investment statements.
- Receivables were reviewed for admittance purposes under NAIC guidelines.
- The accrual for claims payable was reviewed for adequacy. During fieldwork, examiners reviewed actual claims payments made after December 31, 2002 for dates of service during the reporting period.
- Other payables were reviewed for reasonableness.
- Premium revenue was verified through documentation of payments from the TennCare Bureau.

- Other revenues were reviewed for accuracy.

- Medical expenses were reviewed for accuracy by testing payments made through the claims processing system and capitation payments to providers. Effective July 1, 2000, the TennCare contract required VHP to pay medical providers at least 85% of the TennCare capitation payments for the provision of medical services. Additional tests were performed to ensure that medical expenses were recorded in the proper period for the 85% provision.

- Administration expenses were reviewed for accuracy. Examiners determined whether the management fee payments were made in accordance with the management agreement with Vanderbilt Management Services.

- Events subsequent to the reporting period were reviewed to determine the effect on account balances as of December 31, 2000.

D. Results of Financial Test Work Performed

1. Bank Statements and Bank Reconciliations

   During the review of VHP's December 2000 bank reconciliation, the examiners noted that 21 checks dated prior to January 2000 were still on the bank reconciliation. Per VHP's personnel, outstanding checks should be written-off after 6 months.

   Management's Response

   VHP concurs with the finding. In 2001, VHP changed its procedures for writing off outstanding checks. The outstanding list is now reviewed by VHP accounting staff every six months and the necessary steps are taken to reissue or void the checks. In addition, in 2002, VHP has further amended its outstanding check procedures to include the processes and reporting required for unclaimed property in the State of Tennessee.

2. Medical Loss Ratio Reports

   Effective July 1, 2000, Section 3-10.c.1 of the TennCare contract required all TennCare MCOs "… to achieve an annual medical loss ratio of no less than 85% of capitation payments received from TENNCARE based on a fiscal year as an accountability measure for Fiscal Year 2001 while new accountability measures are being developed.…The intent of the 85% medical loss ratio is that 85% of the capitation rate will be spent on covered medical services for eligible TennCare enrollees."

Examiners tested the MLR reports to ensure medical expenses were allowable under the definition of medical expenses as defined in Section 1-3 of the TennCare contract. This review included tests to ensure that administrative costs of the pharmacy benefits contractor were excluded from the calculation of the medical loss ratio. Medical expenses were verified by testing payments by the claims processing systems and other non-system payments for dates of service after July 1, 2000 through March 31, 2001. VHP reported a cumulative MLR for the nine months ended March 31, 2001 of 86.3%.

The following discrepancies were noted in VHP's calculation of the medical loss ratio for March 2001:

- BHO capitation revenue, pharmacy rebates, and recoveries were entered on the MLR report as negative amounts. However, the MLR report automatically subtracts the amounts entered on these rows. Therefore, the entries incorrectly increased, instead of decreased, the total payments for medical expenses.

- The medical expenses reported on the MLR report as capitation payments to physicians for February 2001 included $13,402 in capitation payments to physicians for months prior to July 1, 2000. Medical expenses reported for February 2001 should include only those capitation payments for services provided in February 2001.

- Pharmacy payments for March 2001 on the medical loss ratio report were under reported by $205,377.

Management's Response

VHP concurs with the finding. VHP corrected the MLR report discrepancies as soon as the State Auditors notified the accounting staff. The discrepancies reported and corrected had no negative financial impact on VHP, the State, or VHP's membership.

3. Management Fee Expenses

The management fee for 2000 was not calculated in accordance with the management contract in effect during the year. Under terms of the contract executed January 16, 1998, VHP was obligated to pay VMS an annual management fee consisting of two components, a base fee and, if applicable, an incentive fee. Because the number of enrollees for 2000 was below 22,500, the base fee should have been equal to the actual operating costs of VHP to the extent they did not exceed the approved operating cost of VHP as set forth in the Annual Operating Plan, plus $3.00 per

enrollee. Instead, VHP computed the management fee as 9% of the total premium revenue plus interest income.

Management's Response

Management concurs with the finding. Management fees for the period under examination (January – December 2000) were not calculated in accordance with the management agreement executed in January 1998, for several reasons. First, the 1998 agreement and its financial terms were established by former VMS management and were no longer appropriate for VHP's overall business structure and membership levels. Secondly, in June 1999, VHP's parent, Vanderbilt Health Services (VHS), announced its intentions to sell or discontinue the operations of its owned health plans. Subsequent to the announcement of this decision, VHS and VMS management agreed that it would be appropriate to change the fee percentages to more accurately reflect the true level of expenses being incurred by the management company, as well as to prevent VHS from having to fund additional capital contributions prior to a sale or discontinuance. VHP does not believe that the management fees charged to VHP by VMS to have been excessive in nature and in fact, were actually less than VMS could have charged contractually. Lastly, when VHP was purchased by VMS management effective August 31, 2000, the management fee calculation was changed to reflect the new operating structure of the related companies. Upon approval of the sale of VHP to Windsor Health Group, Inc. (formerly Health Plans Holding Corporation), in March, 2001, a new management contract was executed and approved by the Tennessee Department of Commerce & Insurance.

IX. PROVIDER AGREEMENTS

Four executed contracts were examined to determine if all required elements of Section 2-18. of the TennCare contract were included in the contracts between VHP and their providers. No discrepancies were noted.

X. PROVIDER RECONDISERATION REQUESTS/INDEPENDENT REVIEW

Ten requests from providers that VHP reconsider the partial or total denial of their claims were reviewed and the following discrepancies were noted:

- VHP could not provide documentation for two reconsideration requests. VHP sent one original file to a behavioral health organization without retaining a copy. VHP could not locate the other file.

- VHP did not respond to 6 of the 10 reconsideration requests reviewed within 60 days as required by T.C.A § 56-32-226(b)(2).

For the examination period, no providers had submitted claims partially or totally denied by VHP to TDCI for independent review.

XI. TITLE VI

Effective July 1, 1996, Section 2-25 of the TennCare contract required VHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various VHP staff and a review of policies and related supporting documentation, the examiners determined that VHP was in compliance with Section 2-25 of the TennCare contract.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of VHP.